Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
DR. PETER E. GRAYS

Respondent Name
HARTFORD UNDERWRITERS INSURANCE CO

MFDR Tracking Number
M4-11-0068-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
August 30, 2010

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Separate identifiable procedure performed. No discount should apply."

Amount in Dispute: $332.50

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The insurance carrier did not submit a response for consideration in this review.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 13, 2009	Professional Medical Services	$332.50	$197.29

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.4 requires written notification to health care providers of contractual agreements for informal and voluntary networks.
3. 28 Texas Administrative Code §134.203 sets out the fee guideline for professional medical services.
4. The Division placed a copy of the Medical Fee Dispute Resolution request in the insurance carrier's Austin representative box, which was acknowledged received on September 9, 2010. The insurance carrier did not submit a response for consideration in this review. Per the Division's former rule at 28 Texas Administrative Code §133.307(d)(1), effective May 25, 2008, 33 *Texas Register* 3954, "If the Division does not receive the response information within 14 calendar days of the dispute notification, then the Division may base its decision on the available information." Accordingly, this decision is based on the available information.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 607 – REIMBURSEMENT FOR THIS PROCEDURE HAS BEEN CALCULATED ACCORDING TO THE MULTIPLE PROCEDURE RULE.
   - 663 – REIMBURSEMENT HAS BEEN CALCULATED ACCORDING TO THE STATE FEE SCHEDULE GUIDELINES.
   - 850-664 – W4 NO ADDITIONAL REIMBURSEMENT ALLOWED AFTER REVIEW OF APPEAL/RECONSIDERATION.
   - 989-101 – THIS BILL WAS REVIEWED IN ACCORDANCE WITH YOUR FEE FOR SERVICE CONTRACT WITH FIRST HEALTH.

Issues

1. Are the disputed services subject to a contractual agreement between the parties to this dispute?
2. What is the recommended payment amount for the services in dispute?
3. Is the requestor entitled to reimbursement?

Findings

1. The insurance carrier reduced or denied disputed services with reason code 989-101 – "THIS BILL WAS REVIEWED IN ACCORDANCE WITH YOUR FEE FOR SERVICE CONTRACT WITH FIRST HEALTH." Review of the submitted information finds no documentation to support that the disputed services are subject to a contractual fee arrangement between the parties to this dispute. No documentation was found of to support a contract between the insurance carrier and the health care provider. No documentation was presented to support a contract between the health care provider and the alleged informal or involuntary network. No documentation was found to support that the insurance carrier, Hartford Underwriters Insurance Company, was contracted with the alleged network. No documentation was found to support that the insurance carrier had been granted access to the alleged contractual fee arrangement between the health care provider and the network. No documentation was found to support that the health care provider had been provided any notice, in the time and manner specified by the requirements of 28 Texas Administrative Code §133.4, effective July 27, 2008, 33 Texas Register 5701, applicable to services rendered between August 1, 2008, and December 31, 2010, that the insurance carrier had been granted access to the health care provider's contractual fee arrangement with the alleged network. Consequently, the Division finds that the insurance carrier is not entitled to pay the health care provider at a contracted fee negotiated by an informal or voluntary network. The above denial/reduction reason is not supported. The disputed services will therefore be reviewed for payment in accordance with applicable Division rules and fee guidelines.
2. This dispute relates to professional medical services with reimbursement subject to the provisions of 28 Texas Administrative Code §134.203(b), which requires that, or coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules. §134.203(c) requires that "To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications." It further specifies in subsections (c)(1) and (c)(2) that for the service category of surgery when performed in a facility setting, the established conversion factor to be applied is determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors for each subsequent year based on the conversion factor for calendar year 2008 as listed in §134.203(c)(1). The Division's 2009 conversion factor for surgery when performed in a facility setting, as determined by the Commissioner, is $67.38. The 2009 Medicare payment for procedure code 49507-59-RT performed in the provider's location is $567.16.

   This procedure has a multiple surgery payment policy indicator of 2, which signifies that Medicare's standard payment adjustment rules for multiple procedures apply. When multiple surgeries that are subject to the multiple procedure payment reduction are performed on the same date, the highest paying procedure is paid at 100%; however, payment for each subsequent procedure is reduced by 50%. Procedure code 49561, performed on the same date, is the highest paying procedure code; therefore, per Medicare payment policy, the reimbursement for disputed procedure code 49507-59-RT is reduced by 50%.

   The requestor asserts in the rationale for increased reimbursement from the table of disputed services that "Separate identifiable procedure performed. No discount should apply." While the -59 modifier, if supported by documentation, may be used to distinguish separate services for the purpose of bypassing Medicare's correct coding initiative edits indicating codes that should not be reported together, no edit is being applied in this case. The applicable payment policy is not a CCI edit, but rather the multiple surgery payment reduction policy. Medicare payment policy does not allow the use of modifier -59 to circumvent the multiple procedure payment reduction policy. The requestor did not submit documentation to support any exception to this payment policy. Accordingly, reimbursement is calculated as follows: The Medicare payment of $567.16 is reduced by 50%, resulting in a Medicare payment of $283.58. This amount divided by the Medicare conversion factor of 36.0666 and multiplied by the Division conversion factor of 67.38 results in a MAR of $529.79.
4. The total recommended payment for the services in dispute is $529.79. This amount less the amount previously paid by the insurance carrier of $332.50 leaves an amount due to the requestor of $197.29. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $197.29.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $197.29 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

	Grayson Richardson	May 23, 2014
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.